FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0024265

Facility Name: KNOX ESTATES

Address: PO BOX 706 (Number) STREATOR (City) 61364 (Zip Code)

County: LASALLE

Telephone Number: (815) 673-5574 **Fax #** (815) 673-1714

IDPA ID Number: 36-2558089-042

Date of Initial License for Current Owners: 10/5/80

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	SEC 501(C)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: JEFFREY M. DEAN **Telephone Number:** (815) 673-5574

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/02 to 6/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JEFFREY M. DEAN

(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) D. KEVIN MASON, OWNER

(Firm Name & Address) MASON & ASSOCIATES, CPA'S, 1001 SHOOTING PARK ROAD, STE. 105 B

(Telephone) (815) 223-8808 Fax # (815) 220-3529

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,524			5,524	13
14	TOTALS	5,524			5,524	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.59%

D. How many bed-hold days during this year were paid by Public Aid?
279 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location
Date started 1/5/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary ____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: EXEMPT Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	35,387	2,411	1,865	39,663		39,663		39,663			1
2	Food Purchase		34,916		34,916		34,916		34,916			2
3	Housekeeping	12,168	3,145		15,313		15,313		15,313			3
4	Laundry		4,258		4,258		4,258		4,258			4
5	Heat and Other Utilities			19,496	19,496		19,496	(692)	18,804			5
6	Maintenance	6,086	12,035		18,121		18,121		18,121			6
7	Other (specify):*											7
8	**TOTAL General Services**	53,641	56,765	21,361	131,767		131,767	(692)	131,075			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	260,384	8,226	2,132	270,742		270,742		270,742			10
10a	Therapy			1,896	1,896		1,896		1,896			10a
11	Activities		9,260	803	10,063		10,063		10,063			11
12	Social Services			249	249		249		249			12
13	Nurse Aide Training	808			808		808		808			13
14	Program Transportation		10,709		10,709		10,709		10,709			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	261,192	28,195	5,080	294,467		294,467		294,467			16
	C. General Administration											
17	Administrative							44,164	44,164			17
18	Directors Fees											18
19	Professional Services			1,400	1,400		1,400		1,400			19
20	Dues, Fees, Subscriptions & Promotion			670	670		670		670			20
21	Clerical & General Office Expenses		1,053		1,053		1,053		1,053			21
22	Employee Benefits & Payroll Taxes			92,585	92,585		92,585		92,585			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,169	2,169		2,169		2,169			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,157	2,157		2,157		2,157			26
27	Other (specify):*											27
28	**TOTAL General Administration**		1,053	98,981	100,034		100,034	44,164	144,198			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	314,833	86,013	125,422	526,268		526,268	43,472	569,740			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number KNOX ESTATES #0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,093	11,093		11,093		11,093			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			11,093	11,093		11,093		11,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,608	39,608		39,608		39,608			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			39,608	39,608		39,608		39,608			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	314,833	86,013	176,123	576,969		576,969	43,472	620,441			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(692)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (692)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	44,164	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,164		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 43,472		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Programs					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

KNOX ESTATES

ID# 0024265

Report Period Beginning: 7/1/02

Ending: 6/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KNOX ESTATES # 0024265 **Report Period Beginning:** 7/1/02 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(692)	0	0	0	0	0	0	0	0	0	0	(692)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(692)	0	0	0	0	0	0	0	0	0	0	(692)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	44,164	44,164	0	0	0	0	0	0	0	0	0	88,328	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	44,164	44,164	0	0	0	0	0	0	0	0	0	88,328	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	43,472	44,164	0	0	0	0	0	0	0	0	0	87,636	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KNOX ESTATES # 0024265 **Report Period Beginning:** 7/1/02 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	43,472	44,164	0	0	0	0	0	0	0	0	0	87,636	45

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
STREATOR UNLIMITED, INC.	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT & GENERAL	$	STREATOR UNLIMITED, INC.	100.00%	$ 44,164	$ 44,164	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 44,164	$ * 44,164	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization STREATOR UNLIMITED, INC.
Street Address 305 N. STERLING ST.
City / State / Zip Code STREATOR, IL 61364
Phone Number (815) 673-5574
Fax Number (815) 673-1714

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ALLOWABLE ADMIN. COSTS	CLIENTS/DAYS SERVED	41,714	5	$ 315,456	$ 179,665	5,840	$ 44,164	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 315,456	$ 179,665		$ 44,164	25

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME KNOX ESTATES COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0024265

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,004 B. General Construction Type: Exterior BRICK VENEER Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENTIAL	211,540	1976	$ 26,838	1
2	IDLE	229,115		6,232	2
3	TOTALS	440,655		$ 33,070	3

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1980	1980	$ 347,142	$		$	$	$ 347,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASPHALT ROAD			1986	488	24	20	24		420	9
10	CONNESS BROS.			1986	2,229	112	20	112		1,952	10
11	ELECTRICAL			1987	10,483	524	20	524		9,188	11
12	TILING			1987	828	42	20	42		704	12
13	ADDITION			1992	6,623		10			6,623	13
14	SOIL BORING & PERCOLATION TESTING			1994	1,252	83	15	83		785	14
15	SEWER TILE & LEACH FIELD REMOVAL & REPLACEMENT			1995	26,909	1,794	15	1,794		15,233	15
16	FLOORING			1996	1,083	108	10	108		810	16
17	FLOOR TILE & MOLDING			2001	2,110	106	20	106		190	17
18	ROOF			2001	30,600	1,530	20	1,530		2,621	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 429,747	$ 4,323		$ 4,323	$	$ 385,668	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 36,975	$ 6,312	$ 6,312	$	5 & 7 YRS	$ 19,742	71
72	Current Year Purchases	5,756	458	458		5 & 7 YRS	458	72
73	Fully Depreciated Assets	115,996					115,996	73
74								74
75	TOTALS	$ 158,727	$ 6,770	$ 6,770	$		$ 136,196	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 621,544	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 11,093	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 521,864	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 VAN	$ 8,371	$	$ 8,371	86
87	1994 DODGE VAN	14,802		14,802	87
88	1995 DODGE RAM VAN	5,123		5,123	88
89	1996 DODGE RAM VAN	29,580		29,580	89
90					90
91	TOTALS	$ 57,876	$	$ 57,876	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 16*

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE 16*

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		145		145
4	Clinical Wages (b)		188		188
5	In-House Trainer Wages (c)		475		475
6	Transportation				
7	Contractual Payments			45	45
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 808	$ 45	$ 853
10	SUM OF line 9, col. 1 and 2 (e)	$ 808			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 271,059	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	78,981	334,925	3
4	Supply Inventory (priced at cost)		47,221	4
5	Short-Term Investments			5
6	Prepaid Insurance		24,244	6
7	Other Prepaid Expenses		9,097	7
8	Accounts Receivable (owners or related parties)		19,254	8
9	Other(specify): Bond reserve accounts		249,230	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 78,981	$ 955,030	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		65,010	12
13	Land	33,070	89,020	13
14	Buildings, at Historical Cost	429,747	1,680,340	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	216,603	946,515	16
17	Accumulated Depreciation (book methods)	(521,864)	(1,568,252)	17
18	Deferred Charges		64,277	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 157,556	$ 1,276,910	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 236,537	$ 2,231,940	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,989	$ 71,347	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,386	156,020	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		27,887	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 47,375	$ 255,254	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		870,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 870,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 47,375	$ 1,125,254	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 189,162	$ 1,106,686	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 236,537	$ 2,231,940	48

***(See instructions.)**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 241,414	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 241,414	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,100	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) RELATED ORG. COSTS (SCH. VIII)	(44,164)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 39,936	17
	B. Transfers (Itemize):		
18	STREATOR UNLIMITED, INC.	(92,188)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (92,188)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 189,162	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 650,684	1
2	Discounts and Allowances for all Level	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 650,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	1,492	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic	692	15
16	Rental of Facility Space	858	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,042	23
	D. Non-Operating Revenue		
24	Contributions	7,065	24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,065	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING & RECYCLING	278	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 278	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 661,069	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	131,767	31
32	Health Care	294,467	32
33	General Administratior	100,034	33
	B. Capital Expense		
34	Ownership	11,093	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 576,969	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,100	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,100	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? EXEMPT If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	726	795	14,334	18.03	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Worker					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,880	2,125	17,215	8.10	14
15	Cook Helpers/Assistants	1,927	2,153	18,172	8.44	15
16	Dishwashers					16
17	Maintenance Worker	432	473	6,086	12.87	17
18	Housekeepers	1,731	1,837	12,168	6.62	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,118	1,227	22,094	18.01	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	18,002	20,219	195,252	9.66	30
31	Medical Records	1,788	2,080	29,512	14.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,604	30,909	$ 314,833 *	$ 10.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	34	$ 1,865	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	13	623	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	11	621	10a-3	43
44	Activity Consultant	15	803	11-3	44
45	Social Service Consultant	4	249	12-3	45
46	Other(specify) PSYCHOLOGIST	N/A	1,275	10a-3	46
47	MEDICAL SERVICES	N/A	1,509	10-3	47
48					48
49	TOTAL (lines 35 - 48)	77	$ 6,945		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MASON & ASSOCIATES	ACCOUNTING FEES	$ 1,400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,400

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,645
Unemployment Compensation Insurance	143
FICA Taxes	23,510
Employee Health Insurance	52,153
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT CONTRIBUTION	3,134
TOTAL (agree to Schedule V, line 22, col.8)	$ 92,585

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
FOOD SERVICE SANITATION LICENSE	35
SUBSRIP. - CARE FACILITY RESOURCE	635
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 670

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	974
Seminar Expense	1,195
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,169

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 7/1/02 Ending: 6/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **NO**
If YES, give association name and amount

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **5 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **39,608**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **NO** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **0**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training YES
Indicate the amount of income earned from providing suc
transportation during this reporting period $ **13,579**

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **MASON & ASSOCIATES** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

KNOX ESTATES/STREATOR UNLIMITED, INC.
#0024265
PAGE 15 ATTACHMENT
JULY 1, 2002 - JUNE 30 ,2003

PAGE 15, SECTION XIII, PART A, NUMBERS 2 & 3

* According to DHS Regulations, C.N.A.'s are allowed to competency out of all portions of the training with the exception of CPR and First Aid as well as abuse and neglect prevention, recognition, and intervention. Aide is a C.N.A.

DATE	INDIVIDUAL	TITLE	SEMINAR TITLE	LOCATION	SPONSOR	COST	
7/10 & 7/11/02	D. Burns	Home Mgr.	OIG Investigation	Tinley Park, IL	DHS	$ 62.63	mileage & meals
7/20/2002	M. Klachko	Maintenance	Driver Emergency Preparedness	Elgrove Village, IL	RTAC	17.94	mileage
7/30/2002	D. Burns	Home Mgr.	Abuse & Neglect Incident Rpting.	Tinley Park, IL	DHS	42.44	mileage & meals
	K. Crabtree	RN/QMRP	Abuse & Neglect Incident Rpting.	Tinley Park, IL	DHS		
8/1/2002	D. Burns	Home Mgr.	Rule 50	Elgin, IL	DHS	84.09	mileage & meals
8/22/2002	A. Barry	Housekeeper	1st Aid	Streator, IL	American Red Cross	7.00	
	M. Kozak	Hab. Aide	1st Aid	Streator, IL	American Red Cross	7.00	
8/29/2002	S. Donnell	Hab. Aide	1st Aid	Streator, IL	American Red Cross	7.00	
	M. Hoffmeyer	Hab. Aide	1st Aid	Streator, IL	American Red Cross	7.00	
9/5 - 11/14/02	K. Crabtree	RN/QMRP	QMRP Training	Aurora, IL	Assoc. for Indiv. Dev.	700.00	
9/24 - 10/10/02	D. Washington	Cook	Food Service Sanitation	Oglesby, IL	IL Valley Comm. College	63.25	
						51.25	books
						102.20	mileage
9/21/2002	T. Rowe	Hab. Asst.	CPR	Streator, IL	Kathy Lee	25.00	
9/25/2002	All staff	N/A	Antidepressants/Inservice	Streator, IL	Pharmacy Consultant	53.33	
10/10/2002	D. Burns	Home Mgr.	Handling People w/Tact/Diplomacy	Bloomington, IL	Keystone	61.15	mileage & meals
10/24/2002	D. Burns	Home Mgr.	Positive Attitudes in Cust. Service	Streator, IL	Streator Chamber of Comm.	10.00	
10/29/2002	K. Crabtree	RN/QMRP	Health Risk Screening	Champaign, IL	DHS	99.06	mileage & meals
11/4/2002	L. Renner	Hab. Asst.	CPR	Streator, IL	Kathy Lee	25.00	
	D. Mauk	Cook	CPR	Streator, IL	Kathy Lee	25.00	
11/1 - 11/9/02	A. Burns	Hab. Aide	Activities Orientation	Washington, IL	VSA Arts of Illinois	229.04	mileage & meals
11/18/2002	W. Price	Hab. Aide	1st Aid	Streator, IL	American Red Cross	10.00	
12/2/2002	J. Dean	Ex. Director	Abuse & Neglect Incident Rpting.	Springfield, IL	ICAN	101.63	mileage & meals
	D. Burns	Home Mgr.	Abuse & Neglect Incident Rpting.	Springfield, IL	ICAN		
12/19/2002	N/A	N/A	Tabe Tests	N/A	McGraw Hill	61.36	supplies
12/20/2002	D. Washington	Cook	CPR	Streator, IL	Streator Unlimited, Inc.	3.67	meal

DATE	INDIVIDUAL	TITLE	SEMINAR TITLE	LOCATION	SPONSOR	COST	
	M. Kozak	Hab. Aide	CPR	Streator, IL	Streator Unlimited, Inc.	3.67	meal
1/21/2003	All staff	N/A	Calories/Inservice	Streator, IL	Dietician Consultant	29.12	
2/6/2003	M. Klachko	Maintenance	How to Get More Organized	Springfield, IL	ICAN	13.63	mileage & meals
2/25/2003	C. Beck	Hab. Aide	CPR & 1st Aid	Ottawa, IL	Ottawa Community Hospital	45.00	
2/27 - 2/28/03	K. Crabtree	RN/QMRP	Psychiatric Disorders - DD	Springfield, IL	ICAN	20.00	
						48.16	meals & parking
4/25/2003	D. Mauk	Cook	1st Aid	Streator, IL	American Red Cross	10.00	
	T. Rowe	Hab. Asst.	1st Aid	Streator, IL	American Red Cross	10.00	
5/14/2003	D. Burns	Home Mgr.	Health Care Fraud	Springfield, IL	ICAN	104.47	mileage & meals
6/2/2003	C. Beck	Hab. Aide	Fire Safety	Streator, IL	Streator Unlimited, Inc.	6.98	supplies
	M. Kozak	Hab. Aide	Fire Safety	Streator, IL	Streator Unlimited, Inc.		
6/9/2003	D. Washington	Cook	1st Aid	Streator, IL	American Red Cross	22.20	
	L. Renner	Hab. Asst.	1st Aid	Streator, IL	American Red Cross		
	M. Kozak	Hab. Aide	1st Aid	Streator, IL	American Red Cross		
						$2,169.27	